STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Belmont Manor Nursing Home, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 34 Agassiz Avenue Belmont, MA 02478	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, for one of three sampled Residents (Resident #1), who had a history of wandering, and required the use of a wander guard device for safety, the facility failed to ensure his/her device was consistently checked for function by staff, when on 2/21/26 Resident #1 was able to leave his/her unit, take the elevator to the first floor and exit the building to an outside courtyard, undetected by staff, and without triggering the wander guard alarm system. Resident #1 was outside for around 30 minutes unsupervised, before staff became aware he/she was missing off the unit. Findings include:The Facility Policy, titled, Elopement of a Resident, dated 9/02/08, indicated that all residents are assessed for potential elopement risk on admission, quarterly, annually, and when a resident has a change in condition and a care plan will be implemented for any resident who is at risk along with safety measures to prevent elopement while maintaining the least restrictive environment.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 2/28/26, indicated that on 2/21/26 at 7:00 A.M., Facility staff noted that Resident #1 was not in his/her bed and could not be located on his/her Unit. The Report indicated Resident #1 was last seen in his/her room watching television at approximately 6:30 A.M. The Report further indicated Resident #1 was found on the first floor outside in the courtyard sitting on the ground with his/her walker nearby, he/she was assessed by nursing and no injuries were observed. The Report indicated that staff observed that the wander guard system was not functioning (did not trigger alarm when they brought Resident #1 back inside).Review of Resident #1's Medical Record indicated he/she was admitted in April 2024, diagnoses included Alzheimer's, Dementia, Diabetes, History of falling, Difficulty in walking, and his/her health care proxy was invoked.Review of Resident #1's Physician's orders, dated 12/03/24, indicated he/she had an order for a wander guard bracelet to be placed on his/her walker, and to check function with the universal tester daily on 11:00 P.M. to 7:00 A.M. shift.Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 7 out of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact).Review of Resident #1's Care Plan Titled Elopement, reviewed and renewed with his/her most recent MDS 12/2025, indicated he/she was at risk for elopement, had a history of wandering, that Resident #1 would remove his/her wander guard if on his/her person and therefore it was attached to his/her walker. The Care Plan indicated a goal was for Resident #1 to wander safely within specific bounderies.Review of the most recent Elopement Risk Assessment, dated 2/19/26, indicated that Resident #1 remained at risk for elopement.Review of the Treatment Administration Record (TAR) for the month of February 2026, indicated that on the 11:00 P.M. to 7:00 A.M. shift on 2/21/26, there was no documentation to support that the wander guard check (with the universal tester) had been completed by the nurse. Review of Certified Nurse Aide (CNA) 1's written Witness Statement (included in the Investigation Report), dated 2/21/26, indicated that Resident #1 was last seen by her in his/her room watching television around 6:30 A.M. The Statement indicated CNA #1 assisted with the search for Resident #1, he/she was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found downstairs [in the outside courtyard] and returned to his/her Unit.During a telephone interview on 3/28/26 at 2:13 P.M., Nurse #1 said that when she went to check Resident #1's blood sugar at 7:00 A.M., he/she was not in his/her room or on the unit. Nurse #1 said a search was initiated and he/she was found on the first floor outside in the courtyard area sitting on the ground with his/her walker nearby. Nurse #1 said the wander guard device was attached to Resident #1's walker but was not functioning and had not trigger an alarm. Nurse #1 said because the wander guard device itself was not working, that was how Resident #1 was able to get on the elevator, go down to the first floor, open the door to the courtyard and go outside undetected, because the wander guard system alarm did not sound.Nurse #1 said she was supposed to check the wander guard function during her 11:00 P.M. to 7:00 A.M. shift but did not want to go into Resident #1's room and wake him/her. Nurse #1 said she saw that his/her wander guard device was attached to his/her walker but did not know the wander guard device was not functioning.During an interview on 3/19/26 at 1:03 P.M., Nurse #2 said that she was one of the oncoming nurses for the 7:00 A.M. to 3:00 P.M. shift on 2/21/26 and assisted with the search for Resident #1. Nurse #2 said Resident #1 was found on the first floor outside in the courtyard area sitting on the ground with his/her walker nearby at around 7:00 A.M. and was assessed by nursing. Nurse #2 said Resident #1 had no injuries observed, he/she was placed in a wheelchair and brought back to his/her unit.Nurse #2 said they determined that his/her wander guard device was not functioning. Nurse #2 said the wander guard device should have triggered an alarm when Resident #1 left the unit, should have prevented him/her from accessing the elevator, and then triggered an alarm when he/she tried to go out the exit door to the courtyard.During an interview on 3/19/26 at 12:20 P.M. the Staff Development Nurse said there is a universal tester on each Nursing Unit to check wander guard device function, that facility policy is for wander guard checks to be conducted on the 11:00 P.M. to 7:00 A.M. shift and that the policy is reviewed on orientation and during annual education, with all staff.During an interview on 3/19/26 at 1:12 P.M., the Director of Nursing (DON) said she conducted the investigation into the elopement of Resident #1 and said that Nurse #1 told her she had not checked the functioning of his/her wander guard device on 2/21/26, which resulted in his/her elopement. The DON said nursing staff are expected to follow facility policy and MD orders, and in this case, they had not been done.On 3/19/26, the Facility was found to be in past non-compliance with an effective date of 2/24/26 and provided the Surveyor with a plan of correction which addressed the concern as evidenced by:A. On 2/21/26 Resident #1 was immediately assessed by nursing, no injuries were noted, his/her resident representative and physician were notified, and nursing continued to monitor and support.B. Resident #1 was seen by the Facility Social Worker, and the plan is to move Resident #1 to the secure locked unit as soon as a bed becomes available, and his/her resident representative(family) was in agreement.C. On 2/21/26, the Facility immediately replaced the non-functioning wander guard device with a new one and confirmed the function of the new wander guard.D. On 2/21/26, the Facility immediately tested all wander guard devices, to ensure all residents with devices had functioning ones.E. Resident #1's Care Plan was updated to include additional interventions, such as encourage daytime activities to avoid daytime naps to prevent wandering at night and continue all other orders along with new orders for lab testsF. On 2/23/26, the Facility updated interventions on Resident #1's plan of care to include every 15-minute checks.G. On 2/23/26, re-education of nursing staff was initiated by the Director of Nursing (DON) and Staff Development Coordinator on the Elopement Policy and wander guard testing, placement, and functioning. The Education was completed 2/27/26.H. On 2/23/26, the Facility conducted an ad hoc Quality Assurance Meeting to review the incident and to develop their corrective action plan. I. The Director of Nursing and/or Designee are responsible for overall compliance.